MEDICAL HISTORY

(To be completed by patient)

Name: ______________________ Date: ______________________

Address: ______________________ SS#: ______________________

City, State, Zip: ______________________ Race: ________ Sex: ________ Age: ________

Employer: ______________________ Date of Birth: ______________________

Allergies to Medications: ______________________

Medications currently taking: ______________________

Medical Doctor: ______________________

HAVE YOU EVER HAD:	YES	YEAR	HAVEYOU EVER HAD:	YES	YEAR
1.Cardiovascular			c. Nervous trouble		
a. Heart trouble / angina			7. Urologic		
b. High blood pressure			a. Urinary tract infections		
c. Blood clots			b. Hernia		
d. Blood vessel problems			8. Miscellaneous		
2. Respiratory			a. Ulcer problem		
a. Asthma			b. Diabetes		
b. Bronchitis			c. Skin disease		
c. Pleurisy			d. Other		
d. Pneumonia			Serious Injury		
e. Sinus problems / allergies			Surgical Operations (Explain)		
3. Neurological					
a. Seizures / epilepsy			Patient in Hospital or Clinic:		
b. Head Injury					
c. Stroke			Have you recently or do you have:		
d. Fainting / dizziness			Frequent Headaches		
4. Orthopedic			Frequent Colds or Sore Throat:		
a. Back problems			Earache or Discharge from Ear:		
b. Broken bones			Hearing Loss		
c. Arthritis, joint problems			Chronic Cough		
5. Infectious Disease			Coughing Blood		
a. Tuberculosis			Vomiting Blood		
b. Rheumatic fever			Blood in Stool		
c. Meningitis			Shortness of Breath		
d. Recurrent tonsillitis			Abnormal Vision		
e. Venereal disease			Frequent Indigestion		
f. Other			Hearing Problems		
6. Psychiatric			Menstrual Problems		
a. Alcoholism			Weight-Normal Gain/ Loss		
b. Drug dependency			(Explain)		

I, the undersigned, do hereby certify that the answers to the above questions are true, and give permission for the medical examination. Signed: ______________________

Remarks or additional history by examining physician: ______________________

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